

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/26/2013
NAME OF PROVIDER OR SUPPLIER WILLIAM N WISHARD MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 W 10TH ST INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit is for a State hospital complaint investigation.</p> <p>Complaint: #IN00113183 Unsubstantiated -lack of sufficient evidence.</p> <p>Survey Date: 02/26/13</p> <p>Facility #: 005023</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 03/18/13</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

XIO011

If continuation sheet 1 of 1